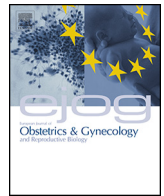




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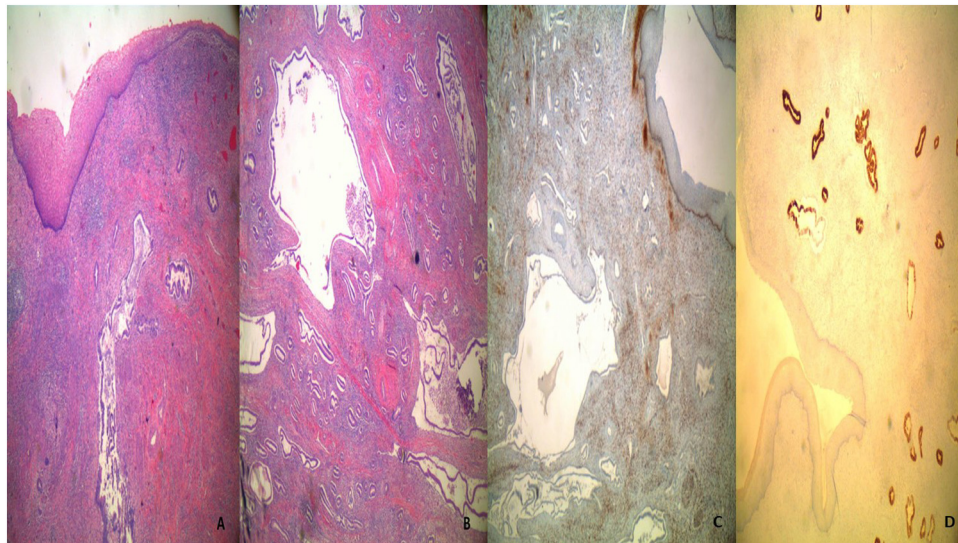
### Short communication

#### A case of gastric-type mucinous endocervical adenocarcinoma in presence of nabothian cysts

Dear Editor,

A group of benign and malignant endocervical glandular lesions unrelated to human papillomavirus (HPV) and showing gastric differentiation, has been described in the last years [1]. Minimal deviation adenocarcinoma (MDA) and lobular endocervical glandular hyperplasia (LEGH) exhibit a gastric phenotype and immunophenotype [2]. Gastric-type adenocarcinoma (GAS) has been recently described as a subtype of cervical adenocarcinoma [3]. These neoplasms have aggressive clinical behavior. There is a likely LEGH-GAS sequence, and an absence of HPV in cases of LEGH, and MDA suggested that this sequence represents an HPV-independent pathway of carcinogenesis [1]. Morphologically defined GAS exhibits immunoreactivity for MUC6 and/or HIK1083, representative markers for pyloric gland differentiation. Notably, GAS is negative for p16INK4a, a marker for high-risk HPV-driven neoplasm [4]. Clinical manifestations include watery vaginal discharge, although women can be asymptomatic [5]. Surgery remains the main treatment for patients with early-stage lesions. Radiotherapy and/or chemotherapy are recommended for women with advanced disease. We described a case of gastric-type mucinous endocervical adenocarcinoma in a woman with positive Pap smear tests for atypical glandular cells of undetermined significance (AGUS) but negative HPV-DNA test. A 46 years old nulliparous woman gave a medical examination for hydorrhea. The gynecological examination showed plentiful mucinous secretions from vagina with vaginal fornix preserved. The specular examination showed an eroded and enlarged cervix. The transvaginal ultrasound (US) scan showed multiple Naboth cysts, as well as an uneven appearance and a plentiful vascularization of the uterus, but regular ovaries. The last two Pap smear tests, performed six months and one year before respectively, showed the presence of atypical glandular cells of undetermined significance (AGUS), so patient underwent colposcopy that confirmed the eroded and enlarged aspect of cervix but turned out to be negative for HPV-related lesions. After 3 months, the patient redid Pap smear test which showed the persistence of AGUS, whereas HPV-DNA test was negative. For this reason, the woman underwent a cervical conization: the histologic examination of cervical sample, measuring 4 × 4 × 2.5 cm, showed a mucinous adenocarcinoma (NOS) moderately differentiated (G2) infiltrating endocervical margin and part of squamous cervical epithelium tissue, with vascular infiltration. Her cancer markers (α-FP, CEA, CA 19-9, CA 15-3, CA 125)

turned out to be all negative. Abdomen and Pelvic MRI showed a tumor that invaded the cervix for all its thickness without involvement of nearby lymph nodes. The patient was referred to our institution and underwent a laparotomy procedure. Uterus and both annexes appeared macroscopically regular. She underwent a total hysterectomy, with bilateral salpingo-oophorectomy and pelvic and obturator lymphadenectomy. Definitive pathologic examination showed a mucinous adenocarcinoma gastric-type, moderately differentiated (G2), infiltrating cervical canal for all its thickness, with a microscopic metastasis in a lymph node isolated in the right parametrium and in two of pelvic and obturator lymph nodes (pT1B1N1) (Fig. 1A–B). Immunohistochemical analysis turned out to be negative for estrogen receptor (ER) and progesterone receptor (PR) (Fig. 1C) and positive for MUC6 (Fig. 1D). The patient is currently being treated with pelvic EBRT (external beam radiation therapy) and concurrent chemotherapy with cisplatin. The diagnosis of GAS is established primarily based on morphology: tumor cells with abundant eosinophilic cytoplasm, distinct cell borders, and a greater degree of cytological atypia characterize it [2,4]. However, immunohistochemistry may contribute to the diagnosis. GAS shows the gastric phenotype, as demonstrated by HIK1083, MUC6, or carbonic anhydrase type IX staining, negativity for p16, as well as a frequent mutant pattern of p53 staining [2]. Unlike MDA and LEGH, the MRI findings of GAS have not been clearly described yet, although image analysis based on T2-WI have recently showed a tumor shape classified as type II, infiltrative [5]. GAS is associated with aggressive behavior and a poor prognosis, including a possible propensity for peritoneal and adnexal dissemination [5]. Indeed, since the first description of GAS in 2007, it has been reported its poorer outcomes than those of usual-type adenocarcinomas (UEA), typically associated to high-risk HPV in over 90% of cases. GAS is rather common in Japan, accounting for up to 20%–25% of all endocervical adenocarcinomas while it is considered rare in Western countries [2]. Kojima et al. showed that GAS had a 5-year disease-specific survival of 30% compared to 77% for UEA [5]. The mean age of presentation ranges between 45–48 years. It's related to high rate of lymphovascular invasion (LVI) and regional lymph node metastases [2]. Here, we discussed the diagnostic difficulties for endocervical glandular lesions with gastric differentiation and the possible relationship with the nabothian cysts. This uncommon entity needs a particular attention for its aggressive behavior and because it is not HPV related. Screening methods for cancer control for the usual endocervical type like HPV DNA testing are ineffective and this may result in a probable delay in diagnosis and a worse prognosis. It would be really interesting to evaluate the role of nabothian cysts in the pathogenesis of this particular tumor.



**Fig. 1.** A–D: A. High view of the adenocarcinoma that resemble the gastric adenocarcinoma, this particular field highlight a lymphovascular invasion; B. It is possible to notice the infiltrative pattern of the adenocarcinoma gastric-type. The glands are composed by cells with high clear cytoplasm and distinct borders; C. Immunohistochemical analysis: negativity for the estrogen and progesterone receptors that are commonly negative in this type of cervix adenocarcinoma; positive controls stated by the fibroblasts in the stroma; D. Immunohistochemical analysis: positivity for MUC6.

## Declaration of interest statement

The authors declare that they have no conflicts of interest and nothing to disclose.

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